2719 Mail Service Center
Raleigh, NC 27699-2719
DIVISION OF HEALTH
SERVICE REGULATION

HEALTH CARE PERSONNEL REGISTRY
INVESTIGATIONS BRANCH
HEALTH CARE PERSONNEL REGISTRY SECTION

PHONE: (919) 855-3968
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N.C. DEPARTMENT OF HEALTH &
HUMAN SERVICES

# 5-WORKING DAY REPORT
# RESULT OF FACILITY ALLEGATION INVESTIGATION TO HCPR

***131E-256(g) The results of all investigations must be reported to the Department [HCPR] within five working days of the initial notification to the Department.***

## FACILITY INFORMATION

Facility Name: _____

Facility Type: _____ Main Office Phone #: ( ) _____ Main 0ffice Fax #: ( ) _____

Facility/Agency License #: _____ Provider # (If Certified): _____ County: _____

Contact Person: _____ Title: _____

Name of Administrator: _____ Title: _____

Actual Incident Location Street: _____ City: _____ State: _____ Zip: _____

MAIN OFFICE Mailing Address Street: _____ City: _____ State: _____ Zip: _____

## ACCUSED NURSE AIDE/HEALTH CARE PERSONNEL INFORMATION *(Required Information)*

Full Name: _____ Title: _____

Social Security #: _____ Date of Birth: _____ Date of Hire: _____

Last Known Address: _____ City: _____ State: _____ Zip: _____

Driver's License # _____ Other Information: _____

Home Phone #: ( ) _____ Other Number (Cellular, Pager, Work, etc.): ( ) _____

## ALLEGATION TYPE *(Check all that Apply)*

- ☐ 1. RESIDENT ABUSE
- ☐ 2. RESIDENT NEGLECT
- ☐ 3. DIVERSION OF RESIDENT DRUGS (Estimated Value:_____)
- ☐ 4. DIVERSION OF FACILITY DRUGS (Estimated Value:_____)
- ☐ 5. FRAUD AGAINST RESIDENT
- ☐ 6. FRAUD AGAINST FACILITY
- ☐ 7. MISAPPROPRIATION OF FACILITY PROPERTY (Estimated Value:_____)
- ☐ 8. MISAPPROPRIATION OF RESIDENT ROPERTY (Estimated Value:_____)
- ☐ 9. * INJURY OF UNKNOWN SOURCE * *Explain under "Additional Information"*

## SPECIFIC ALLEGATION

Date and Time of Occurrence**:** _____ Exact Location of Incident: _____

**Description:** _____

## RESIDENT INFORMATION

NAME: _____ DOB: _____ AGE: _____

Resident's Address (If different from facility): _____ City: _____ State: _____ Zip: _____

Interviewable?: ☐ No ☐ Yes Diagnoses: _____

**Physical Injury/Harm?** ☐ No ☐ Yes

If **Yes**, describe physical harm of resident:

**Mental Anguish >5 days?** ☐ No ☐ Yes

If **Yes**, describe emotional response & behaviors of resident:

## RESIDENT INFORMATION *(Continued)*

**Memory & Orientation**: _____

## RESIDENT'S TYPE OF CARE: *(Please Check)*

☐ Adult Care ☐ Home Care ☐ Acute Care ☐ NF/SNF ☐ Hospice

☐ Mental Illness ☐ Developmental Disability ☐ Substance Abuse ☐ Other: _____

## WITNESS(es)

☐ No ☐ Yes Number of Witnesses _____ *(Include resident/victim if resident was a witness. Indicate witness' relationship to the resident/victim and the accused.)*

Full Name: _____ Title/Relationship: _____

Last Known Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: ( ) Other Number (Cellular, Pager, Work, etc.): ( )

Full Name: _____ Title/Relationship: _____

Last Known Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: ( ) Other Number (Cellular, Pager, Work, etc.): ( )

***(ADDITIONAL WITNESSES MAY BE LISTED ON AN ATTACHED SHEET)***

## ACTION TAKEN BY FACILITY *(Please Fill in all Blanks that Apply)*

Allegation Substantiated by Facility?: ☐ No ☐ Yes Date Facility Investigation Completed: _____

Person Who Conducted Facility Investigation: _____ Title: _____

Was the Accused Terminated from Employment?: ☐ No ☐ Yes If Yes, Date Terminated: _____

Other Action:

Was Incident Reported to Local Dept. of Social Services (DSS)?: ☐ No ☐ Yes Date Reported: _____

☐ Adult Protective Services
☐ Child Protective Services
☐ Adult Home Specialist

County: _____ On-Site Visit by DSS? ☐ No ☐ Yes Date of On-Site Visit: _____

Name of DSS Investigator: _____ Phone #: ( )

Was Incident Reported to Police?: ☐ No ☐ Yes Date Reported to Police: _____ Date Police Investigated: _____

Name of Police Department: _____ Phone #: ( )

Name of Investigator: _____ Title: _____

Charged? ☐ No ☐ Yes If Yes, Specific Charges: _____

## *PLEASE ***INCLUDE*** THE FOLLOWING INFORMATION WITH YOUR REPORT*

☐ **Details of facility investigation**

☐ **Documentation of injury/harm to victim**

☐ **Other Supporting/Pertinent Documents:** *(Specify)* _____

**Additional Information:**

(Printed Name and Title of Person Preparing Report) (Signature of Person Preparing Report) Date